TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Memorial Compounding Pharmacy

**Respondent Name**
Liberty Mutual Fire Insurance Company

**MFDR Tracking Number**
M4-19-2992-01

**Carrier's Austin Representative**
Box Number 1

**MFDR Date Received**
January 31, 2019

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "This compound has been proven to be effective and it not the first line of therapy or care based on the patient's date of injury."

**Amount in Dispute:** $569.93

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Your issue will be forwarded to the appropriate department for further handling."

**Response Submitted by:** Liberty Mutual Insurance

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| August 13, 2018 | Compound Medication | $569.93 | $569.93 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

**Background**

1. 28 Texas Administrative Code §133.240 sets out the procedures for payment and denial of medical bills.
2. 28 Texas Administrative Code §133.305 sets out the procedures for resolving medical disputes.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.502 sets out the procedures for billing pharmaceutical services.
5. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
6. Texas Insurance Code, Chapter 19 sets out the requirements for utilization review.
7. The insurance carrier reduced payment for the disputed compound based on medical necessity.

**Issues**

1. Is this dispute subject to dismissal based on medical necessity?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to additional reimbursement?

**Findings**

1. Memorial is seeking reimbursement for a compound dispensed on August 13, 2018. Per explanation of benefits dated October 9, 2018, the insurance carrier denied the disputed compound based on medical necessity.

   Medical necessity disputes must be resolved prior to submission of a medical fee dispute.[1] The insurance carrier is required to perform a utilization review before a denial based on medical necessity, including giving the health care provider – in this case, Memorial – an opportunity to discuss the treatment in question.[2]

   The respondent is required to submit documentation to support a denial based on lack of medical necessity.[3] Liberty Mutual Fire Insurance Company provided no evidence to support that it performed a utilization review on the compound in question to determine medical necessity.[4]

   This denial reason is not supported. Therefore, this dispute is not subject to dismissal based on medical necessity.

2. Because the insurance carrier failed to sufficiently support its denial of reimbursement, Memorial is entitled to reimbursement.

   The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.[5] Each ingredient is listed below with its reimbursement amount.[6] The calculation of the total allowable amount is as follows:

| Drug | NDC | Generic(G) /Brand(B) | Price /Unit | Units Billed | AWP Formula | Billed Amt | Lesser of AWP and Billed |
|---|---|---|---|---|---|---|---|
| Gabapentin USP | 38779246109 | G | $59.85 | 3 | $224.44 | $179.55 | $179.55 |
| Amitriptyline HCl | 38779018904 | G | $18.24 | 2.4 | $54.72 | $43.78 | $43.78 |
| Amantadine HCl | 38779041105 | G | $24.23 | 4.8 | $145.35 | $116.30 | $116.30 |
| Flurbiprofen | 38779036209 | G | $36.58 | 4.8 | $219.48 | $175.58 | $175.58 |
| Bupivacaine HCl | 38779052405 | G | $45.60 | 1.2 | $68.40 | $54.72 | $54.72 |
| | | | | | | Total | $569.93 |

   The total reimbursement is therefore $569.93. This amount is recommended.

**Conclusion**

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $569.93.

[1] 28 Texas Administrative Code §133.305(b)
[2] 28 Texas Administrative Code §133.240(q)
[3] 28 Texas Administrative Code §133.307(d)(2)(I)
[4] 28 Texas Administrative Codes §§134.240 and 19.2009
[5] 28 Texas Administrative Code §134.502(d)(2)
[6] 28 Texas Administrative Code §134.503(c)

## *ORDER*

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
The DWC hereby ORDERS the respondent to remit to the requestor $569.93, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

| | Laurie Garnes | October 11, 2019 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.